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Impact of a Single-Session of Havening

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Abstract

Introduction: In the UK, the economic cost of absenteeism, loss in productivity and the demand on health care services is considerable. A substantial amount of time off work certified by a doctor is due to common mental disorders. There is a need for rapid and effective interventions at step 2 of the care system.

Objective: The impact of a single-session of a brief intervention, called Havening, in addressing depression, anxiety and impaired functioning in the workplace are presented.

The aim of this study was to explore the efficacy of a single-session of Havening in improving self-reported impaired occupational functioning.

Methods: Twenty-seven participants completed the Patient Health Questionnaire depression module (PHQ-9), Generalised Anxiety Disorder Assessment (GAD-7) and the Work and Social Adjustment Scale (WSAS) before, 1-week and 2-months after the Havening intervention.

Results: The single-session of the Havening intervention had a positive impact on probable depression (PHQ-9), probable anxiety (GAD-7) and work and social adjustment (WSAS) scores over time. The scores on all three measures improved over time. A significant effect for time was observed PHQ-9 ($\chi^2(2) = 30.79$, $p<0.001$), the GAD-7 ($\chi^2(2) = 38.18$, $p<0.001$) and the WSAS ($\chi^2(2) = 22.62$, $p<0.001$).

Conclusion: The single-session of Havening proved efficacious in reducing self-reported symptoms on the PHQ-9, GAD-7 and the WSAS in a sample of participants who reported being occupationally impaired.

Keywords: Brief-intervention; Anxiety; Depression; Occupational impairment; Havening

Introduction

Recent data suggest that around 15% of the population may be affected by common mental health disorders, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder [1]. According to the Office of National Statistics, the 1-week prevalence rates were 4.4% for generalised anxiety disorder, 3.0% for PTSD and 2.3% for depression [2].

In industrialised nations, mental health disorders are the leading cause of sickness-related absence [3]. In the UK, 47-61% of the total time off work certified by a doctor is accounted for by common mental disorders [4] and 37% of all claims for employment support allowance are due to common mental disorders [5]. As a result, the economic cost of absenteeism, loss in productivity and demand on health care services is considerable [6].

These data have led to improved provision of psychological therapies in the treatment of depression and anxiety to, at least in part; help ensure that the pool of people who are fit to work is enlarged. One of the long-term aims of the improved provision of psychological therapies is to reduce the cost of Incapacity Benefit leading to potential savings for the Department of Work and Pensions (DWP). Furthermore, the introduction of new therapeutic provision, such as the Improving Access to Psychological Therapies (IAPT) initiative, has aimed to overcome the previously unbalanced provision of psychological therapy, long waiting times, and lack of consistency in implementing NICE guidelines for depression and anxiety [7]. However, there is still

room for improvement in the provision of psychological therapies including the need to explore the efficacy of brief interventions [8].

Brief interventions have proven to be effective in depression, anxiety and loss as well as substance use disorders, such as harmful drinking [9]. The WHO Brief Intervention Study Group found that five minutes of simple advice was as effective as 20 minutes of counselling [10]. They help to fill the gap between primary prevention efforts and more intensive treatment for individuals who have clinically significant disorders such as psychosis, depression associated with suicidality and serious alcohol use disorders [11].

Havening is a novel brief intervention being utilised in the treatment of depression and anxiety. Havening aims to treat depression and anxiety symptoms caused due to traumatic encoding of negative events [12] by using sensory input to alter thoughts, mood and behaviour. During Havening, the negative event and the associated emotional state are recalled and the practitioner applies a gentle touch to the forearms, which is coupled with distracting tasks. This process increases the levels of serotonin which can disrupt reconsolidation of the link between the traumatic memory of the event and the distress it causes [13].

Given the potential versatility of Havening in treating trauma related mental health problems, [12] if shown to be effective it could be a useful therapy for step 2 of a stepped care system [1].

Aim

The aim of this study was to evaluate the impact of a single-session of the Havening intervention on self-reported symptoms of probable depression, symptoms of probable anxiety and work and social adjustment scores in a sample of participants who reported being occupationally impaired.

Method

A snowball recruitment method was used whereby participants were recruited, by a psychologist, who contacted individuals, via email, who had reported being occupationally impaired as a result of depression and / or anxiety. Recipients of the email were asked to pass it on to other professionals they knew who might want to seek help for self-reported mental health problems. It is not possible to ascertain how many people in total would have received the recruitment email although the initial direct approach was made to 37 individuals.

A between subjects design was used to test the impact of a single administration of Havening on the scores of self-reported depression, anxiety and functional impairment. Data were collected before the Havening intervention (T1), one week after the intervention (T2) and two months after (T3). The data collected from participants were completely anonymous and it is not possible to identify participants from the resulting article.

Participants, who reported being occupationally impaired due to depression or anxiety, were offered the opportunity to receive a single-session of Havening to assist them in regaining their occupational fitness. According to the participants all self-reported symptoms had persistently impaired their occupational functioning. Participants completed the PRIME-MD Patient Health Questionnaire (PHQ-9), the PRIME-MD Generalised Anxiety Disorder Assessment (GAD-7) and the Work and Social Adjustment questionnaires (WSAS).

The PHQ-9 is a measure of depressive symptoms often used in primary care; it enquires about each of the 9 DSM-IV depression criteria as “0” (not at all) to “3” (nearly every day). The maximum score of the PHQ-9 is 27; lower scores demonstrate lower levels of depression. Scores of 5, 10, 15, and 20 represent cut-off points for mild, moderate, moderately severe and severe depression respectively. The diagnostic validity of the 9-item PHQ-9 has been established primary care and obstetrical settings and studies show that PHQ-9 scores > 10 have a sensitivity of 88% and a specificity of 88% for major depressive disorder. The internal consistency of the PHQ-9 has been shown to be high. A study involving two different patient populations produced Cronbach alphas of 0.86 and 0.89 [14].

The GAD-7 is a self-report questionnaire for screening generalised anxiety disorder. GAD-7 has seven items which measure severity of various signs of generalized anxiety disorder according to reported response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day”. Scores of 5, 10 and 15 are cut-off points for mild, moderate, and severe anxiety respectively. Validation studies have shown that the GAD-7 has sensitivity of 89% and specificity of 82% for generalized anxiety disorder [15].

The WSAS is a simple 5-item patient self-report measure that assesses the impact of a person’s mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. The WSAS asks participants to rate the extent to which their problems were affecting work and social life. Validation studies of the WSAS have shown that it is a reliable and valid measure of impaired functioning, with a reported Cronbach's alpha range from 0.70 to 0.94 [16].

Havening is a protocol based intervention and there are three ways in which it can be delivered; facilitated Havening (directly delivered by the therapist), facilitated self-Havening (therapist present) and self-Havening (no therapist). This session used both facilitated and facilitated self-Havening. The Havening facilitator demonstrated the process on five of the 30 participants.

Participants were asked to:

i. Find an exact word or phrase that represented their current emotional difficultly. Participants scaled the word/phrase from 1-10, with 10 being the highest/most distressing score.

ii. Clear their mind or to think about something nice.

iii. Use both their hands to tap on both their collarbones whilst opening and closing their eyes twice.

iv. Continue tapping, keep their head still, and to move their eyes fully to the left and to the right and then down to the left and down to the right and finally in a full circle clockwise and then anti clockwise in front of their face, keeping their head still.

v. Place their arms across their chest and close their eyes; whilst their eyes were closed, the facilitator asked them to imagine walking up a flight of stairs and to count out loud from 1 to 20 with each step that they took.

vi. With consent, the facilitator (or the participants themselves if self-Havening) gently rubbed the sides of the participant's arms, for the duration of the counting, whilst counting with them.

vii. Re-scale the emotion 1-10. And the procedure (ii – vi) was repeated with the visual element and auditory element changed slightly; i.e. instead of climbing up stairs it was to visualise skipping over a rope and instead of counting 1-20 participants hummed Happy Birthday.

viii. Allow their arms drop and relax, to move their eyes in circles and then to close their eyes, whilst the researcher stroked the sides of their arms again 5 times and used the words "Let it Go" on the final stroke. Finally the participants were asked to open their eyes and scale the feeling on 1-10 again. This was repeated until the scale was given 1-3.

Instructions were given to the those participants who had not experienced facilitated-Havening on how to conduct facilitated self-Havening which was then carried out in pairs with the facilitator ensuring that participants were comfortable with the procedure. Havening continued until participants felt that their difficulties had improved considerably (scoring three or less) or did not improve any further. Participants were reminded to complete their questionnaire one week and two months after the Havening intervention.

Data were collected using an online survey tool and then transferred into SPSS for analysis. Due to the data not fulfilling the assumptions of normality, and due to small numbers, the non-parametric Freidman test, followed by Post-hoc Wilcoxon signed rank tests using the Bonferroni correction, was conducted to compare scores at T1 (before Havening), T2 (one-week following Havening) and T3 (two-months after Havening). All analyses were performed using SPSS for windows version 18.0.

Results

The study had a follow-up rate of 86% with 27 participants completing the questionnaire at all three time points. Sixty-seven per cent of the participants reported that they had been experiencing the occupational impairment for more than two years and 22% reported having experienced the problem for between one and two years (**Table 1**).

The results showed a significant effect for time from T1 – T3 on the PHQ-9 ($\chi^2(2) = 30.79$, $p<0.001$), the GAD-7 ($\chi^2(2) = 38.18$, $p<0.001$) and the WSAS ($\chi^2(2) = 22.62$, $p<0.001$). Post-hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level set at $p < 0.017$. Overall, participants reported an improvement on all mental health measures, which were sustained at two months, after the Havening intervention. Participants reported statistically significant changes in scores from before to one-week after Havening on the PHQ-9 ($Z = -4.28$, $p <0.001$), the GAD-7 ($Z = -4.37$, $p <0.001$), and WSAS ($Z = -3.56$, $p <0.001$). A reduction in scores was reported 2-months after the Havening treatment on the PHQ-9 ($Z = -4.03$, $p <0.001$), the GAD-7 ($Z = -4.29$, $p <0.001$) and the WSAS ($Z = -3.45$, $p <0.001$) (**Table 2**).

Discussion

This report presents the results from a single-session of Havening in treating self-reported depression, anxiety and occupational impairment. The results demonstrate that a single-session of Havening had a positive effect on reducing scores on the PHQ-9, GAD-7 and WSAS. Participants reported that this improvement in scores was sustained one-week and two-months after the intervention.

Table 1 Demographic details of Havening sample.

Age		n (%)
	25-29	1 (4)
	30-34	1 (4)
	35-39	3 (11)
	40-49	11 (41)
	50+	11 (41)
Marital status		
	Married	13 (48)
	Living with a partner	3 (11)
	In a long-term relationship	1 (4)
	Single	4 (15)
	Separated	1 (4)
	Divorced	4 (15)
	Widowed	1 (4)
Employment status		
	Employed	13 (48)
	Self-employed	7 (26)
	Retired	3 (11)
	Unemployed	4 (15)
Duration of problem		
	A month – a year	3 (11)
	One – two years	6 (22)
	More than two years	18 (67)

Note: Number and percentage, may not add up to 100%

Table 2 Friedman test and post-hoc Wilcoxon Signed-Ranks test with Bonferroni correction to test for significant changes in scores from T1 – T3.

Scales	Friedman test	Wilcoxon Signed-Ranks test P Value (vs. T1)	
		T2	T3
	$x^2(2)$, p-value	z, p-value	z, p-value
PHQ-9	30.79, 0.00***	-4.28, 0.00***	-4.03, 0.00***
GAD-7	38.18, 0.00***	-4.37, 0.00***	-4.29, 0.00***
WSAS	22.62, 0.00***	-3.56, 0.00***	-3.45, 0.00***

Note: Wilcoxon Signed-Rank Test using Bonferroni adjustment (new p value: 0.05/3 = 0.017), *** p <0.001, ** p<0.01, * p<0.05, n.s = non-significant.

These findings are in line with previous evaluations of a similar psychosensory therapy. A randomised controlled trial compared the effectiveness of psychosensory therapy, which included an extrasensory stimulus in the form of tapping alongside diaphragmatic breathing, for specific phobias, such as insects, rats and spiders. Following a single session of diaphragmatic breathing, patients who received this psychosensory therapy showed an improvement in their phobias which was sustained over time [17]. Similarly, in a randomised trial of 5000 patients, psychosensory therapy was more effective in treating common mental health problems than Cognitive Behaviour Therapy (CBT) or medication. Furthermore, at one-year follow-up, the patients receiving the psychosensory treatment were less prone to relapse or partial relapse than those receiving CBT or medication [18]. However, it must be noted that the evaluation by Andrade and colleagues [18] was limited in its generalisability by informal record-keeping, subjective outcome assessments, and variables that were not rigorously controlled.

The results of this study suggest that Havening might be a suitable therapy in step 2 of the care system given the positive impact of a single-session which can be self-facilitated. Systematic reviews for anxiety and depression [19] have evaluated various aspects of self-help interventions and have endorsed their use as interventions for mild to moderate anxiety and depression. Furthermore, some self-help therapies for depression have been shown to have an enduring effect at follow-up [20]. Guided self-help interventions have been imbedded within the mental health services, in the form of IAPT, which provide assessments and offer brief self-help interventions, cognitive restructuring and support with computerised CBT programmes.

Our data show that the Havening intervention may well be capable of rapidly improving depression, anxiety and impaired functioning through a single-session. Furthermore, the effects of the therapy were not short-lived as our results showed that participants reported sustained improvement up to two-months after the Havening process. Since the Havening technique is simple enough to administer to subjects and teach them how to re-administer it during future episodes of distress, it could offer a substantial advantage over more complicated interventions which can only be delivered by high trained therapists over multiple sessions if more robust, comparative trials of Havening continue to demonstrate that it is effective.

Limitations of the Study

This study is limited by its small sample size, lack of control group and that the sample selection was opportunistic which is therefore likely to be non-representative of the working population. Furthermore, the participants were all healthcare professionals who are likely to be more engaged and open to psychotherapy. Given the limitations of this study the results should be regarded as preliminary.

Conclusions

The single-session of the Havening intervention resulted in improved scores on the PHQ-9, GAD-7 and the WSAS and these improvements were sustained over time. The Havening intervention could prove to be a useful and cost-effective intervention for common mental disorders at step 2 of the care system.

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